SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Physicians Mutual Insurance Company

Product Name: Medicare Supplement Plan N	SERFF Tr Num: PHYS-127059634	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 48457
Sub-TOI: MS08I.011 Plan N 2010	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Author: Sonja Morton	Disposition Date: 05/11/2011
	Date Submitted: 04/11/2011	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 03/07/2011
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/11/2011
	State Status Changed: 05/11/2011
Deemer Date:	Created By: Sonja Morton
Submitted By: Sonja Morton	Corresponding Filing Tracking Number:

Filing Description:

RE: Physicians Mutual Insurance Company – NAIC 80578 - Group 367, FEIN 47-0270450
Individual Medicare Supplement
P029AR – Medicare Supplement Plan N Policy
M-NB-MSA001-AR-T – Medicare Supplement Application/Dental Enrollment/Life Application & Variables
C029-AR – Medicare Supplement Outline of Coverage Cover Page (replaces C020-AR approved 8-12-09)
OC029-UNI – Medicare Supplement Outline of Coverage for Plan N
Actuarial Memorandum for Plan N
Rates: P029-AR-032511

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

The captioned forms and rates are submitted for your review and approval. The forms are new and do not replace any forms previously approved by your Department unless noted above. To the best of my knowledge, they comply with all state laws and regulations.

The is a combination of a Medicare Supplement Application, Dental Enrollment and Life Application. This application will also be used with currently approved Medicare Supplement policies and any additional Standardized plans approved in the future. The Dental Enrollment section of the application will guarantee issue the C250C certificate which was approved by your Department on July 21, 2003, or any similar product approved in the future. The Life Application section will be used to guarantee issue Modified Whole Life Policy L728AR policy approved by your Department on November 10, 1999, or any approved life insurance plan underwritten by Physicians Life Insurance Company. This application will also be filed for Physicians Life Insurance Company in a separate filing.

This product will be sold through our Agency distribution.

We reserve the right to alter the format of the forms without re-filing due to future technology changes, e.g. paper size, font, font type, line ending or page ending changes. Be assured that any minimum font-sized requirements will be met. Any changes to wording or content would be filed for approval.

Your early review and approval of this filing is greatly appreciated. If there is anything I can do to facilitate the review and approval, please contact me via SERFF, or at the e-mail address or phone number listed below.

Sincerely,

Sonja Morton
Product Approval & Compliance Coordinator
Government and Industry
Voice: 402-633-1662
Fax: (402) 633-1096
E-mail: sonja.morton@physiciansmutual.com

Company and Contact

Filing Contact Information

Sonja Morton, Policy Approval & Compliance Coordinator
2600 Dodge Street
Omaha, NE 68131

sonja.morton@physiciansmutual.com
402-633-1662 [Phone]
402-633-1096 [FAX]

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Filing Company Information

Physicians Mutual Insurance Company	CoCode: 80578	State of Domicile: Nebraska
2600 Dodge Street	Group Code: 367	Company Type:
Omaha, NE 68131	Group Name:	State ID Number:
(402) 633-1188 ext. [Phone]	FEIN Number: 47-0270450	

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	No
Fee Explanation:	The filing fee per form for all types of filings is $50 per form. We are filing four (4) forms, so the filing fee is $200.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Physicians Mutual Insurance Company	$200.00	04/11/2011	46449849

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	05/11/2011	05/11/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	05/03/2011	05/03/2011	Sonja Morton	05/04/2011	05/04/2011

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/11/2011
Implementation Date:
Status: Approved-Closed
Comment: This approval is subject to the following:

• Increases will not be given more frequently than once in a twelve-month period;

• The insured shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
Physicians Mutual Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document *(revised)*	Application	Approved	Yes
Supporting Document	Application	Disapproved	No
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Underlined Copy of Application M-NB-MSA001-AR-T	Approved	Yes
Form	Medicare Supplement Plan N Policy	Approved	Yes
Rate	P029AR Rates	Approved	Yes

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/03/2011
Submitted Date	05/03/2011
Respond By Date	06/03/2011

Dear Sonja Morton,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application (Supporting Document)

Comment: R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Objection 2

- Application (Supporting Document)

Comment: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered."

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/04/2011
Submitted Date	05/04/2011

Dear Stephanie Fowler,

Comments:
Thank you for your letter.

Response 1

Comments: The tobacco question, question #9, was actually in the health question area of the application. We agree that this was not obviously indicated on our application. We have added the statement that you asked us to add in reference to Objection 2 as follows: "Under Open Enrollment, health questions 8 – 24 are not required to be answered." This wording was added above the health questions on page 3 of the application.

Related Objection 1

Applies To:

- Application (Supporting Document)

Comment:

R&R 27, Sec. 11 prohibits discrimination of pricing during Open Enrollment. The Tobacco Use question is an underwriting question and we ask that it be moved to the Medical Question section since it is not required to be answered during Open Enrollment.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Application
Comment: We also included a Statement of Variability for the application.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Comments: As indicated in our response to Objection 1, we have added the requested statement to our application. An underlined copy of the application is attached to identify the addition of this statement to our application.

Related Objection 1

Applies To:

- Application (Supporting Document)

Comment:

R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered."

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Underlined Copy of Application M-NB-MSA001-AR-T

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for pointing out this revision. If you have additional questions, or if additional information is needed, please be sure to let me know. Thank you!

Sincerely,
Sonja Morton

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: P029AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 05/11/2011	P029AR	Policy/Contract/Fraternal Certificate	Medicare Supplement Plan N Policy	Initial		51.100	P029AR.pdf

PHYSICIANS MUTUAL INSURANCE COMPANY
2600 DODGE ST. OMAHA, NE 68131

MEDICARE SUPPLEMENT PLAN N POLICY

Notice to Buyer: This Policy may not cover all of Your medical expenses.

TABLE OF CONTENTS

Consideration: This Policy is issued in consideration of the Application and payment of the first premium.

IMPORTANT NOTICES

Entire Contract; Changes: This Contract is between Physicians Mutual Insurance Company ("We", "Us", "Our", or "Company") and the Insured shown on the Schedule ("You", "Your", or "Insured"). The entire contract is the Policy, the Schedule, the Application and any riders signed by a Company Officer. No change in this Policy will be effective until approved by a Company Officer. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions. All statements made in the Application are deemed representations and not warranties.

30 Day Right To Examine The Policy: If You return the Policy within 30 days after You receive it, We will return Your money. Then, the Policy is void as if no Policy had been issued.

Read Your Application: Be sure Your Application is correct and complete. We rely on all statements made by You or for You on the Application You signed. If any statement is incorrect or incomplete, notify Us immediately. Unless corrected, Your Policy may be void.

GUARANTEED RENEWAL AGREEMENT

Guaranteed Renewable With Timely Payment: You can keep Your Policy in force as long as You pay Your Renewal Premiums on time. When We receive Your Renewal Premium before the Grace Period ends, We must accept it. Renewal Premium means any Policy premium due Us after Your first premium payment has been made.

Premium Changes: We may change Your Renewal Premium, only if We make the same change for all policies of this form and class in the State where You live.

We will not increase Your premium earlier than 12 months after the Effective Date of this Policy, nor will We increase Your premium more than once in any 12 month period after 12 months from the Effective Date of this Policy, unless You no longer qualify for a premium discount.

Grace Period: You have 31 days after the due date to pay each Renewal Premium. The Policy stays in effect during this Grace Period.

Late Payment Lapse: If We do not receive Your Renewal Premium before the Grace Period ends, Your coverage stops at the end of the Grace Period. This is a Lapse and Your Policy is no longer in force.

Reinstatement: If Your Policy Lapses, We may or may not put it back in force (reinstate) at our option. If We accept a late premium and do not require an application, Your Policy is reinstated. If We require an application, Your Policy is reinstated when We approve the application, or (unless We have already disapproved it in writing) on the 45th day after We receive the application.

The reinstated Policy is in force to cover loss that starts after the reinstatement. In all other respects, the Policy remains the same except for any provisions noted on or attached to the reinstated Policy.

Changes in Medicare: Any benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, and coinsurance amounts. Your premiums may be modified to correspond with such changes.

Extension of Benefits: Termination shall be without prejudice to any continuous loss which began while the Policy was in force. Any extension of benefits beyond that time may be conditional upon the continuous total disability of the Insured, limited to the appropriate benefit period or payment of maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

Medicaid Suspension: The benefits and premiums under this Policy will be suspended during Your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If You are no longer entitled to Medicaid, Your Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

Group Health Plan Suspension: The benefits and premiums under this Policy will be suspended at Your request if You are entitled to benefits under Section 226(b) of the Social Security Act (disabled under age 65) and are covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act (group health insurance coverage with an employer that has 20 or more employees). If You then lose coverage under Your group health plan, Your Policy will be reinstituted automatically effective as of the date of Your group health plan termination. You must notify Us of the coverage termination within 90 days after the date of coverage termination and pay the premium attributable to the period.

BENEFITS

This Policy is designed to supplement the Federal Medicare Program. You must have Medicare as primary coverage for this Policy to supplement. If You are not enrolled in Part B of Medicare, We will pay benefits as if You were enrolled.

Your Policy benefits will be adjusted whenever Medicare changes its benefits. We may adjust the Renewal Premium accordingly, subject to the Premium Changes provision.

If You incur expenses, We will pay benefits as follows:

BASIC BENEFITS

Inpatient Hospital Benefit: We will pay the Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.

Additional Inpatient Hospital Benefit: We will pay for Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

Lifetime Maximum Inpatient Hospital Benefit: Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, We will pay 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider will accept Our payment as payment in full and may not bill You for any balance.

Blood: We will pay for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), covered under Medicare Parts A and B, unless replaced in accordance with federal regulations.

Medical Benefits: After You satisfy the Medicare Part B deductible for each Calendar Year, we will pay benefits for Medicare Eligible Expenses under Part B as follows:

(a) For each covered health care provider office visit, including visits to medical specialists, We will pay the coinsurance amount less the Co-payment to be paid by You.

(b) For each covered emergency room visit, We will pay the coinsurance amount less the Co-payment to be paid by You, unless You are admitted to a Hospital and the emergency visit is subsequently covered as a Medicare Part A expense. In this case the Co-payment is waived and We will pay the coinsurance amount.

(c) For all other Medicare Eligible Expenses under Part B, We will pay the coinsurance amount, regardless of Hospital confinement.

Hospice Care: We will pay the cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

ADDITIONAL BENEFITS

Medicare Part A Deductible: We will pay the Medicare Part A inpatient Hospital deductible amount per Medicare Benefit Period.

Skilled Nursing Facility Care: We will pay the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A.

Foreign Travel Emergency: We will pay to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a Calendar Year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Accident or a Sickness of sudden or unexpected onset.

POLICY LIMITATIONS`

We will not pay for:

(a) confinement that begins or expenses incurred while Your Policy is not in force.

(b) services of the type not covered by Medicare, unless specifically provided by the Policy.

PAYMENT OF CLAIMS

Notice of Claim: Written notice of claim must be given within 20 days after a covered accident or sickness or as soon as reasonably possible. Written notice should include Your name and Policy number and should be sent to Physicians Mutual Insurance Company, P.O. Box 2018, Omaha, NE 68131.

Claim Forms: We will send You claim forms after We receive notice of claim. For a continuing loss We will furnish forms with each periodic benefit payment. If We do not furnish forms within 15 days, You can submit proof of loss (a written statement of the nature and extent of the loss) without using our claim forms.

Proof of Loss: We require written proof that a claim exists within the terms of Your Policy. Except in the absence of legal capacity, such proof must be given no later than 15 months from the date of loss.

Time of Payment: We will pay all claims due as soon as We have valid proof.

Payment of Claims: We will pay the benefits to You, unless You assign the benefits to another. If, at the time of Your death, there is an unpaid benefit, We will pay it to Your estate; however, We may pay up to $1,000 of it to any relative by blood or connection by marriage We find entitled. Our obligation is satisfied to the extent of such payment.

DEFINITIONS

Accident means accidental bodily injury sustained by You, which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and occurs while Your Policy is in force.

Calendar Year is as defined in the Medicare program.

Co-payment is the amount to be paid by You for office visits and emergency room visits after Your Medicare Part B deductible has been satisfied each Calendar Year. The Co-payment amount is equal to the lesser of the Medicare Part B coinsurance amount for each visit and the dollar amount shown on the Policy Schedule.

Hospice Care is as defined in the Medicare program.

Hospital is as defined in the Medicare program.

Medicare means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended, or Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof.

Medicare Benefit Period is as defined in the Medicare program.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Parts A and B to the extent recognized as reasonable and medically necessary by Medicare.

Physician is as defined in the Medicare program.

Respite Care is as defined in the Medicare program.

Sickness means Your illness or disease.

Skilled Nursing Facility is as defined in the Medicare program.

GENERAL PROVISIONS

Time Limit on Certain Defenses: After two years from the date of issue of this Policy no misstatements, except fraudulent misstatements, made by the applicant in the Application for such Policy shall be used to void the Policy or to deny a claim for loss incurred after the expiration of such two-year period.

No claim for loss commencing after the Policy Effective Date should be reduced or denied on the grounds that a disease or physical condition existed prior to the Policy Effective Date.

Misstatement Of Age: If Your age was misstated and a different premium would have been charged, the benefits will be adjusted to what the premium paid would have purchased using the correct age.

Refund of Unearned Premiums: If You die while Your Policy is in force, We will refund any unearned premium paid for any period beyond the end of the policy month in which the death occurred. Any unearned premium will be paid no later than 30 days after We receive proof of Your death.

Legal Actions: You can't bring a legal action to recover under the Policy: (a) until 60 days after You have given written proof of loss, or (b) more than three years after the date proof of loss is required.

Other Insurance With This Company: You may have only one Medicare Supplement Policy with us. If, in error, We issue more than one, You, Your beneficiary, or Your estate may select the Policy to remain in force. We will refund the money You paid on the other Policy, less the amount of claims paid.

Conformity With State Statutes: Any provision of this Policy in conflict with the laws of the state where You reside on its Effective Date is Amended to the minimum requirements of those laws.

Policy Issue - First Premium: If the First Premium shown in the Schedule has been paid, this Policy goes into effect on the Effective Date shown in the Schedule.

Periods of Insurance: All periods of insurance begin and end at 12:01 A.M., Standard Time at Your residence.

Dividends: This Policy is non-participating and does not pay dividends.

Annual Meetings: The annual meeting is held at 12 o'clock, noon, on the third Saturday of February at the Home Office.

Physicians Mutual Insurance Company,

R. A. Reed

President

SCHEDULE

PLAN N

999-9999-99999-99999

Policy Number	XXX-XXX-XXX-X	Insured – John	Age XX
Effective Date	07/01/2011		
First Renewal Date	08/01/2011		
First Premium	$X,XXX.XX		

		Renewal Premium
	*ABW	$XXX.XX
Name of Insured:	*Monthly	$XXX.XX
	*Quarterly	$X,XXX.XX
John Q. Doe	*Semi-annual	$X,XXX.XX
	*Annual	$X,XXX.XX

PLAN N PAYS:

PART A BENEFITS -

Part A deductible amount per Medicare Benefit Period

Coinsurance – 61st to 90th day

Coinsurance – 91st to 150th day
(Lifetime reserve days)

Pays the same benefits that Medicare was paying when benefits exhausted
(Maximum of 365 days)

Coinsurance for Skilled Nursing Facility Care – 21st to 100th day

First three pints of blood

Hospice Care cost sharing

PART B BENEFITS -

Generally 20% of Medicare Eligible Expenses, Subject to Medicare Part B deductible and Co-payments for:
- office visits – up to [$20.00]
- emergency room visits – up to [$50.00]

First three pints of blood

Foreign Travel Emergency medical benefits – 80% to a lifetime maximum of $50,000

These are just brief descriptions of the benefits payable under the Plan N Medicare Supplement Policy. See your Policy for complete descriptions of benefits.

The information shown on this schedule is current as of [the effective date shown above.]

*Subject to premium changes provision.

P029AR
[Duplicate Policy to replace original.]

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	SERFF
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	03/28/2011
Filing Method of Last Filing:	SERFF

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Physicians Mutual Insurance Company	N/A	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 05/11/2011	P029AR Rates	P029AR	New		P029AR Rates.pdf

Exhibit A

Proposed

Issue Age

Rate Table

PHYSICIANS MUTUAL INSURANCE COMPANY

Table of Rates

Medicare Supplement Policy

PLAN N

ARKANSAS
2011

Automatic Bank Withdrawal
Base Premiums

Age	Agency Issue Age
65-99	$ 192.20

Please refer to AREA-PMIC-020911 for areas and factors.

Please refer to MS-DISCOUNT-STD-040709 for discounts and age forgiveness rating.

To obtain Monthly rates, add $5 to the above-quoted Automatic Bank Withdrawal rates. To obtain Quarterly, Semi-Annual, and Annual rates, multiply the above quoted Automatic Bank Withdrawal by 3, 6, and 12 respectively.

P029-AR-032511

Exhibit B

Schedule

for

Zip Codes

and

Area Factors

Physicians Mutual Insurance Company
Omaha, Nebraska
MEDICARE SUPPLEMENT
AREA RATING ZIP CODES

Plans A, B, F, N and HDF

Area A 0.75	Area B 0.80	Area C 0.85	Area D 0.90	Area E 0.95	Area F 1.00	Area G 1.05	Area H 1.10	Area I 1.15	Area J 1.20	Area K 1.25	Area L 1.30	Area M 1.35	Area N 1.40	Area O 1.45	Area P 1.50	Area Q 1.55	Area R 1.60	Area S 1.65	Area T 1.70	Area U 1.75	Area V 1.80	Area W 1.85	Area X 1.90	Area Y 1.95	Area Z 2.00
226-229	500-516, 520	201, 220-225	155, 157-188	030-038, 254	150-154, 156	354-355, 370	189-194	247-248	703-704	320, 327	770, 772, 775		322, 328-329	700	701		330-334		900-921						
239-246	522-525	230-238	195-196	257, 261-268	206-219, 199	372, 401-402	197-198, 323	258-259, 321	750-753, 757	335-336, 338			337, 339, 346				340-341, 343		926-928						
521, 538	527-528, 535	386-388	304-307,310	290-291, 293	249-253	705-706, 710	350-352, 395	324-326, 344	773-774, 777	342, 347			484-485				345, 348-349		940-941						
545-547	537, 539-540	390-393	312, 315-319	296-298	255-256, 260	755-756	440, 443-445	436, 441	794	922-925, 933							480-483		943-944						
	544, 548-549	396-397, 526	389, 398	377-383, 385	270-289, 292	758-759	488-489, 492	486-487		935, 945-949															
	656-658	541-543, 559	437-438, 446	394, 403-427	294-295, 299	763-765	600-608, 620	707-708, 711																	
		613, 634-639	449, 460, 461	430, 432-433	300-303	778-781	622, 722, 776	714, 754																	
		644-648	465-468, 470	448, 456-458	308-309, 311	783-789, 793	782, 800-802	760-762																	
		650-655	472-475, 499	462, 469, 471	313-314	805, 850-853	804, 806	889-891																	
		683-684, 686	530, 550, 553	476-479	356-369, 371	855-857, 859	930-932,934																		
		688-693	556-558	490-491	373-376, 384	860, 863	936-939																		
		843-844, 847	560-567	494-495, 498	399, 400, 431	864-865	950-954																		
		976, 978-979	570-577	551, 554	434-435, 439	959-961																			
			580-588	609-612	442, 447																				
			590-599, 685	614-616	450-455																				
			687, 748	617-619	463-464, 493																				
			820-831	623-629, 666	496-497																				
			83414	716-718	531-532, 534																				
			840-842	723-729, 730	630-631, 633																				
			873-874	734-741	640-641																				
			877-884	743-747, 749	660-662																				
			973-975, 977	797-798, 803	664-665																				
			995-999	807-809	667-681																				
				810-816, 839	712-713																				
				845-846, 870	719-721, 731																				
				875, 893-895	766-769																				
				897-898, 942	790-792																				
				955-958, 982	795-796, 799																				
				986, 988-991	871-872																				
				993-994	967-968																				
					970-972																				
					980-981																				
					983-985, 992																				

All Other Plans

Area A 0.75	Area B 0.80	Area C 0.85	Area D 0.90	Area E 0.95	Area F 1.00	Area G 1.05	Area H 1.10	Area I 1.15	Area J 1.20	Area K 1.25	Area L 1.30	Area M 1.35	Area N 1.40	Area O 1.45	Area P 1.50	Area Q 1.55	Area R 1.60	Area S 1.65	Area T 1.70	Area U 1.75	Area V 1.80	Area W 1.85	Area X 1.90	Area Y 1.95	Area Z 2.00
226-229	500-516	201, 220-225	155, 157-188	030-038	199, 206-219	189-194	197-198, 323	247-248	757, 773, 794	320, 327	770, 772		322, 328-329	701			330-334		900-921						
239-246	520, 522-525	230-238	195-196	150-154, 156	249-253	350-352	395, 441	258-259, 321		335-336, 338			337, 339, 346				340-341, 343		926-928						
521, 538	527-528, 535	386-388	304-307, 310	254, 257	255-256, 260	354-355, 440	443-445	324-326, 344		342, 347, 775			484-485, 700				345, 348-349		940-941						
545-547	537, 539-540	390-393	312, 315-319	261-268	270-289, 292	605, 620, 622	488-489, 492	436, 486-487		922-925, 933							480-483		943-944						
	544, 548-549	396-397, 446	389, 398, 410	290-291, 293	294-295, 299	705-706, 710	600-604	703-704, 711		935, 945-949															
	656-658	460-461, 526	430, 432	296-298	313-314	755-756	606-608	714, 750-754																	
		541-543, 559	437-438, 449	300-303	356-364	758-759	707-708, 722	774, 777, 889																	
		613, 634-639	462, 465-468	308-309, 311	367-370	763-764, 776	760-762																		
		644-648	470, 472-475	365-366, 371	372-375, 384	778-779	890-891																		
		650-655	479, 499, 530	376-383, 385	401-402, 439	782-789, 793	930-932,934																		
		683-684, 686	550, 553	394, 399, 400	442, 447	800-802, 804	936-939																		
		688-693	556-558	403-409	450-455, 463	806	950-954																		
		843-844, 847	560-567	411-427	464, 493	959-961																			
		973-979	570-577	431, 433	496-497																				
			580-588	434-435, 448	531-532, 534																				
			590-599, 685	456-458, 469	630-631,633																				
			687, 730	471, 476-478	640-641																				
			740-741, 748	490-491	660-662																				
			814-816	494-495, 498	664-665																				
			820-831	551, 554	667-680																				
			83414	609-612	712-713																				
			840-842, 870	614-616	719-721																				
			873-874	617-619	765-769																				
			877-880	623-629, 666	780-781																				
			881-882	681, 716-718	790-792																				
			883-884	723-729, 731	795-796, 799																				
			995-999	734-739	805, 850-853																				
				743-747, 749	855-857																				
				797-798, 803	859, 860																				
				807-813, 839	863-865																				
				845-846	967-968																				
				871-872, 875	980-981																				
				893-895	983-985, 992																				
				897-898, 942																					
				955-958																					
				970-972, 982																					
				986, 988-991																					
				993-994																					

Exhibit C

Schedule

For

Discounts

PHYSICIANS MUTUAL INSURANCE COMPANY
2600 DODGE STREET
OMAHA, NEBRASKA 68131

MEDICARE SUPPLEMENT
AVAILABLE DISCOUNTS
AGENT SOLICITED BUSINESS

Discount	Amount
Non-Tobacco Discount Only	10%
Long-Term Care Discount Only	10%
Annuity Discount Only	5%
Non-Tobacco Discount with Long-Term Care Discount	20%
Non-Tobacco Discount with Annuity Discount	15%
Long-Term Care Discount with Annuity Discount	15%
Non-Tobacco Discount with Long-Term Care, and Annuity Discounts	25%
Medicare Supplement Household Discount	$5 per Month

MS-DISCOUNT-STD-040709

SERFF Tracking Number:	*PHYS-127059634*	*State:*	*Arkansas*
Filing Company:	*Physicians Mutual Insurance Company*	*State Tracking Number:*	*48457*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.011 Plan N 2010*
Product Name:	*Medicare Supplement Plan N*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	05/11/2011

Comments:

Attachment:

READCERT Standard - PMIC.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	05/11/2011

Comments:

We also included a Statement of Variability for the application.

Attachments:

Statement of Variability for AR.pdf

M-NB-MSA001-AR-T.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	05/11/2011

Comments:

Attachments:

C029-AR.pdf

OC029-UNI.pdf

		Item Status:	Status Date:
Satisfied - Item:	Underlined Copy of Application M-NB-MSA001-AR-T	Approved	05/11/2011

Comments:

Attachment:

M-NB-MSA001-AR-T Underlined.pdf

PHYSICIANS MUTUAL INSURANCE COMPANY

OMAHA, NEBRASKA

Certification of Flesch

These form(s) have the following Flesch Readability Score:

Form	Flesch Score
P029 52.4	
M-NB-MSA001-AA	40.0*

The entire form was analyzed. The following was excluded in the text: name and address of the insurer; name, number and title of the rider; captions and subcaptions; medical terminology; defined terms.

*When scored with the base policy, the Flesch score will always be the minimum required by statute.

Vice President
Physicians Mutual Insurance Company

March 18, 2011
Date

Statement of Variability
Application M-NB-MSA001-AR-T
Revised 04/05/11

a. May delete from the title if option to enroll in dental coverage is removed from the application.

b. May delete from the title if option to apply for life coverage is removed from the application.

c. May delete this item, or add/delete/change instructional copy.

d. May delete this item, or add/delete/change instructional copy.

e. May rearrange the layout or change format of this section. May change location of this section in the application. May delete/change items or add/change instructional copy.

f. May rearrange the layout or change format of this section. May change location of this section in the application. May add/delete/change Plans offered, or modify plan names or add instructional copy.

g. May add/move/delete/change the payment method options, as well as instructional copy.

h. May add/move/delete/change premium information, as well as instructional copy.

i. Will not change wording to health questions 10 and 11, but may delete questions 10 and 11 and instructional copy preceding and following those questions if we change the application to have all ages of applicants answer all the same health questions. Other question numbers would be renumbered accordingly.

j. May delete instructional copy preceding question 12 if we change the application to have all ages of applicants answer all the same health questions. Other question numbers would be renumbered accordingly.

k. May rearrange the layout or change format of this section. May change location of this section in the application. May delete this section.

l. May add/delete/change Plans offered.

m. May delete/change spouse information requested, or add instructional copy.

n. May add/delete/change Schedules offered.

o. May add/move/delete/change the payment method options, as well as instructional copy.

p. May add/move/delete/change premium information, as well as instructional copy.

q. May rearrange the layout or change format of this section. May change location of this section in the application. May delete this section.

r. May add/delete/change Policies offered.

s. May add/delete/change Face Amounts offered.

t. May add/delete/change Riders offered. May add/delete/change Face Amounts of Riders offered.

u. May add/delete/change the number of beneficiaries and/or contingent beneficiaries listed. May add/delete/change instructional copy.

v. May delete this item, or add/change instructional copy.

w. May delete if plans offered do not have a cash value.

x. May delete this item, or add/change instructional copy.

y. May add/move/delete/change the payment method options, as well as instructional copy.

z. May add/move/delete/change premium information, as well as instructional copy.

aa. May delete this item if dental insurance is not offered. May add/change/delete plan(s) offered.

bb. May delete this item if life insurance is not offered. May add/change/delete plan(s) offered.

cc. May delete this item if life insurance is not offered.

dd. May delete this item if life insurance is not offered.

Physicians Mutual Insurance Company
Physicians Life Insurance Company
Underwriting Services
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Application for Medicare Supplement
[Optional Dental Enrollment] ⓐ
[Optional Life Insurance Application] ⓑ

Plan Selection

Please **initial** the following coverage(s) for which you are applying:

____	Medicare Supplement Insurance Underwritten by Physicians Mutual Insurance Company Complete the Medicare Supplement Plan Information and Questions Sections
____	Dental Insurance Underwritten by Physicians Mutual Insurance Company Complete the Optional Dental Plan Information Section ⓒ
____	Life Insurance Underwritten by Physicians Life Insurance Company Complete the Optional Life Insurance Application Section ⓓ

Personal Information (please print)

Applicant's Name _____ Date of Birth ___/___/___ Age ____
First Middle Initial Last Month Day Year

Address _____ ☐ Female ☐ Male
Street Apartment Number

_____
City State Zip Code

Phone Number ( ) _____ Social Security Number ___ — ___ — ____

Date of Application ___/___/___ Email Address _____
Month Day Year

ⓔ

Medicare Supplement Plan Information

Requested Effective Date ___/___/___
Month Day Year

Applicant's Medicare Health Insurance Claim Number (HICN)
(exactly as shown on your Medicare card) | | | | | | | | | | | |

Plan Selection (check one)	Rate Structure (check one)
☐ Plan A/P020 ☐ Plan F/P025 ☐ High Deductible Plan F/P027 ☐ Plan G/P026 ☐ Plan N/P029	☐ Community Rating (10)
☐ Plan F/P025 With Innovative Discount Rider/B345	☐ Community Rating (20)

ⓕ

Payment Options: [☐ ABW (monthly) Type 1 ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] ⓖ

[Modal Premium Selected $ _____ Monthly Premium $ _____] ⓗ

Medicare Supplement Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.
PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge: YES NO

1. Are you covered under Medicare Part A? ☐ ☐
   If yes, what is your Part A effective date? ____/____/____ (Month / Day / Year)
   If no, what is your eligibility date? ____/____/____ (Month / Day / Year)
2. Are you covered under Medicare Part B? ☐ ☐
   If yes, what is your Part B effective date? ____/____/____ (Month / Day / Year)
   If no, what date do you plan to enroll? ____/____/____ (Month / Day / Year)
3. Did you turn age 65 in the last six months? ☐ ☐
   3a. Will you turn age 65 in the next six months? ☐ ☐
   3b. Did you enroll in Medicare Part B in the last six months? ☐ ☐
   If yes, what is your effective date? ____/____/____ (Month / Day / Year)

If you answered "YES" to any portion of question 3, you do not need to answer questions 8 – 24.

4. Are you covered for medical assistance through the state Medicaid program? ☐ ☐
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.
   If yes:
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ ☐
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ ☐

YES NO

5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   Start Date ____/____/____ (Month / Day / Year) End Date ____/____/____ (Month / Day / Year)
   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ ☐
   If yes, please show requested date of termination/disenrollment ____/____/____ (Month / Day / Year)
   b. Was this your first time in this type of Medicare plan? ☐ ☐
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ ☐

YES NO

6. Do you have another Medicare Supplement policy in force? ☐ ☐
   a. If so, with what company and what plan do you have? _____
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ ☐
   If yes, enter requested date of termination/disenrollment ____/____/____ (Month / Day / Year)

	YES	NO
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)	☐	☐

a. If so, with what company and what kind of policy? _____

_____

b. What are your dates off coverage under the other policy? (If you are still covered under this plan, leave "END" blank) Start Date ____/____/____ (Month/Day/Year) End Date ____/____/____ (Month/Day/Year)

c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ ☐

If yes, please show requested date of termination/disenrollment. ____/____/____ (Month/Day/Year)

Under Open Enrollment, health questions 8 – 24 are not required to be answered.

8. Please provide your height _____(ft./in.) and weight _____(lbs.)

	YES	NO
9. Have you used tobacco products in the past 12 months?	☐	☐

Answer questions 10 and 11 only if you will be 68 years of age or younger on the effective date of the coverage for which you are applying. Otherwise, go to question 12.

	YES	NO
10. Do any of these apply to you:		
• Have end stage renal (kidney) disease	☐	☐
• Currently receiving dialysis	☐	☐
• Diagnosed with kidney disease that may require dialysis	☐	☐
• Diagnosed with or treated for internal cancer or melanoma within the past two years	☐	☐
• Admitted to the hospital as an inpatient within the past three months	☐	☐
• Have insulin dependent diabetes	☐	☐
• Use oxygen as a treatment for a diagnosed medical condition	☐	☐
11. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:		
• Hospital admittance as an inpatient	☐	☐
• Any surgery (including cataract surgery)	☐	☐
• Use of oxygen	☐	☐

Note: If you answered "YES" to any item in question 10 or 11, you will not qualify for coverage.

Answer questions 12 – 24 only if you will be over 68 years of age on the effective date of the coverage for which you are applying. Otherwise, skip questions 12 – 24.

	YES	NO
12. Have you been hospitalized or confined to a nursing home within the past 90 days, or have you been hospitalized two or more times in the past 12 months?	☐	☐
13. Do you require the use of a walker?	☐	☐
14. Are you bedridden, or do you require the use of a wheelchair?	☐	☐
15. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Dementia, or any other cognitive disorder?	☐	☐
16. Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)?	☐	☐
17. Are you taking prescription drugs for both diabetes and a heart condition (including high blood pressure)?	☐	☐
18. Are you taking anti-coagulant (blood thinner) drugs?	☐	☐

	YES	NO
19. Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery)	☐	☐
20. Within the past two years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following:		
• alcoholism; drug addiction (or drug abuse)	☐	☐
• internal cancer; leukemia; malignant melanoma;	☐	☐
• congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder, heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stent);	☐	☐
• insulin dependent diabetes;	☐	☐
• systemic lupus erythematosus (SLE);	☐	☐
• multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease;	☐	☐
• fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine;	☐	☐
• liver disease; chronic kidney disorder; kidney failure; kidney dialysis;	☐	☐
• chronic obstructive pulmonary disease (COPD) or emphysema;	☐	☐
• an illness or condition for which you use oxygen;	☐	☐
• stroke; transient ischemic attack (TIA);	☐	☐
Note: If you answered "YES" to any of questions 12-20, you will not qualify for coverage.		
21. Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder?	☐	☐
22. In the past 12 months have you received medical treatment in an assisted living facility?	☐	☐
If yes, please explain. _____		
_____		
23. Do you have a mental disease or disorder requiring medication (including depression)?	☐	☐

24. In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines? ☐ ☐

If "YES," indicate the specifics below:

Medication Name	Quantity Taken	Dosage	Prescribing Physician	Illness for Which Medication Prescribed	Date Last Prescribed

Important Statements to be Read by Medicare Supplement Applicant

(1) You do not need more than one Medicare Supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Optional Dental Plan Enrollment (Not required for issue of Medicare Supplement)

Dental Certificate C250 issued to the Delaware Group Insurance Trust

Plan Selection (check one) [☐ Applicant Only ☐ Applicant/Spouse] (l)

Spouse Information (only if Applicant/Spouse dental coverage is selected):

Spouse's Name _____ (m)
First Middle Initial Last

Date of Birth ____ / ____ / ____ Age _____ ☐ Male ☐ Female
Month Day Year

(k)

Choose your level of benefits: Schedule: [☐ A ☐ D ☐ E] (n)

Requested Effective Date ____ / ____ / ____
Month Day Year

Payment Options: [☐ ABW (monthly) ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] (o)

[Modal Premium Selected $ _____ Monthly Premium $ _____] (p)

Optional Life Insurance Application (Not required for issue of Medicare Supplement)

Life Policy [L728, Modified Whole Life Insurance] (r) Underwritten by Physicians Life Insurance Company

Face Amount:

[☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000 ☐ $9,000 ☐ $10,000] (s)

Optional Accidental Death Benefit (Rider LR-49):

☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000 ☐ $9,000 ☐ $10,000 (t)

Beneficiary's Name _____ _____ _____ _____ (u)
First Middle Initial Last Relationship to Insured

Contingent Beneficiary's Name _____ _____ _____ _____ (q)
First Middle Initial Last Relationship to Insured

Do you have any existing life insurance or annuities? ☐ Yes ☐ No

[If yes, the Replacement of Life Insurance or Annuities form must be completed.] (v)

In the event of nonpayment of premiums, do you wish to use part of your cash value (if any) as a loan to pay the past due amount to keep your coverage in force? ☐ Yes ☐ No (w)

[Requested Effective Date ____/____/____] (x)
Month Day Year

Payment Options: [☐ ABW (monthly) ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] (y)

[Modal Premium Selected $ _____ Monthly Premium $ _____] (z)

This statement applies only to the Medicare Supplement application: The Undersigned applicant and insurance producer certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the Medicare Supplement policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

This statement applies only to applicants enrolling for optional Dental Certificate C250: I am enrolling for Certificate C250 and the plan selected issued to the Delaware Group Insurance Trust. I understand no coverage is in force until the Company issues a certificate showing a Certificate Effective Date and the first full premium has been paid. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (aa)

This statement applies only to applicants for optional Life Insurance Policy L728: I understand that the Life Insurance coverage I am applying for will not be in force until my application has been received by Physicians Life Insurance Company and my first premium has been paid during my lifetime. I also understand that a reduced death benefit amount is payable during the first two years. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (bb)

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

X _____
Applicant's Signature

Date Application Completed ____/____/____ Dated at _____ _____
Month Day Year City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. I also certify that only Company approved sales material was used in connection with this sale [, and copies of all Life sales materials used were left with the applicant, if the existing Life policy is being replaced]. (dd)

This Medicare Supplement policy ☐ does replace ☐ does not replace any insurance presently in force.

[This Life Insurance policy (if applied for) ☐ does replace ☐ does not replace any insurance presently in force.] (cc)

X	X
Licensed Resident Insurance Producer's Signature	Licensed Resident Insurance Producer's Signature
Licensed Resident Insurance Producer's Printed Name	Licensed Resident Insurance Producer's Printed Name
Licensed Resident Insurance Producer's NPN	Licensed Resident Insurance Producer's NPN

To Be Filled Out By Insurance Producer

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force:

Physicians Mutual Insurance Company

Benefit Chart of Medicare Supplement Plans Sold For Effective Dates on or After June 1, 2010.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A coinsurance.

A	B	C	D	F	F*	F**	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*			Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $[20] copayment for office visit, and up to $[50] copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance			Skilled Nursing Facility Coinsurance				
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible			Part A Deductible				
		Part B Deductible		Part B Deductible							
				Part B Excess (100%)			Part B Excess (100%)	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
										Foreign Travel Emergency	Foreign Travel Emergency
								Out-of-Pocket limit $[4640]; paid at 100% after limit reached	Out-of-Pocket limit $[2320]; paid at 100% after limit reached		

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate Foreign Travel Emergency deductible.**

****A High Deductible Premium Discount Rider is also available to add to Plan F. The addition of this Rider will provide the same benefits as a standard High Deductible Plan F from the effective date of the policy until the Deductible Elimination Date as defined on the Policy Schedule. On or after the Deductible Elimination Date, the benefits provided will be standard Plan F benefits. If you terminate the rider prior to the Deductible Elimination Date, the benefits revert to standard Plan F benefits.**

Automatic Rate Withdrawal Rates*
Zip Codes: 716-718, 723-729

Non-Tobacco Rates							Tobacco Rates						
Age	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**	**Age**	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**
65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]

Automatic Rate Withdrawal Rates*
Zip Codes: 719-721

Non-Tobacco Rates							Tobacco Rates						
Age	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**	**Age**	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**
65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]

Automatic Rate Withdrawal Rates*
Zip Code: 722

Non-Tobacco Rates							Tobacco Rates						
Age	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**	**Age**	**Plan A**	**Plan F**	**Plan F w/Rider****	**High Ded. Plan F**	**Plan G**	**Plan N**
65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	65-99	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]	[$XX.XX]

To calculate monthly premiums, first apply all discounts and then add $5.00 to the A.B.W. premium. For other modes, first apply all discounts and then multiply the A.B.W. premium by the following factors: Annual-12, Semi-annual-6, Quarterly-3.

* See Premium Information regarding Discounts for LTC, Annuity and Household discounts.

** Rider is the High Deductible Premium Discount Rider, an optional rider only available with Plan F.

PREMIUM INFORMATION
We, Physicians Mutual Insurance Company, can only raise your premium if we raise the premium for all policies of this form and class in your state, or if you no longer qualify for a premium discount. Premiums never increase because of age, but can receive increases to cover changes in Medicare benefits and inflation.

LTC, ANNUITY, AND HOUSEHOLD DISCOUNTS
We provide a discount off your Medicare Supplement premium if you own a Long-Term Care policy or an Annuity from Physicians Mutual or Physicians Life Insurance Company that meets our requirements. The discount for your Medicare Supplement policy is 10% for Long-Term Care and 5% for an Annuity. If you reside with another person who owns a Medicare Supplement policy with Physicians Mutual or Physicians Life, we will provide you a $5.00 per month Household discount off your Medicare Supplement premium. All discounts are applied prior to adding $5.00 for monthly direct premiums if you select this mode. All these discounts may be used in conjunction with each other. The discounts will be removed if you no longer meet our requirements.

DISCLOSURES
Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY
If you find that you are not satisfied with your policy, you may return it to Physicians Mutual, 2600 Dodge Street, Omaha, NE 68131. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE
This policy may not fully cover all of your medical costs. Neither Physicians Mutual nor its insurance producers are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN N

PHYSICIANS MUTUAL INSURANCE COMPANY
MEDICARE SUPPLEMENT
OUTLINE OF COVERAGE

P-020 Series

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,132]	$[1,132] (Part A Deductible)	$0
61st thru 90th day	All but $[283] a day	$[283] a day	$0
91st day and after - While using 60 lifetime reserve days	All but $[566] a day	$[566] a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[141.50] a day	Up to $[141.50] a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[162] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $[162] of Medicare Approved Amounts*	$0	$0	$[162] (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints	$0	All Costs	$0
Next $[162] of Medicare Approved Amounts*	$0	$0	$[162] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE **MEDICARE APPROVED SERVICES** -Medically necessary skilled care services and medical supplies	100%	$0	$0
-Durable medical equipment First $[162] of Medicare Approved Amounts*	$0	$0	$[162] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Physicians Mutual Insurance Company
Physicians Life Insurance Company
Underwriting Services
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Application for Medicare Supplement
[Optional Dental Enrollment] ⓐ
[Optional Life Insurance Application] ⓑ

Plan Selection

Please **initial** the following coverage(s) for which you are applying:

____	Medicare Supplement Insurance Underwritten by Physicians Mutual Insurance Company Complete the Medicare Supplement Plan Information and Questions Sections
____	Dental Insurance Underwritten by Physicians Mutual Insurance Company Complete the Optional Dental Plan Information Section ⓒ
____	Life Insurance Underwritten by Physicians Life Insurance Company Complete the Optional Life Insurance Application Section ⓓ

Personal Information (please print)

Applicant's Name _____ Date of Birth ___/___/___ Age ____
First Middle Initial Last Month Day Year

Address _____ ☐ Female ☐ Male
Street Apartment Number

_____
City State Zip Code

Phone Number ( ) _____ Social Security Number ___ — ___ — ____

Date of Application ___/___/___ Email Address _____
Month Day Year

ⓔ

Medicare Supplement Plan Information

Requested Effective Date ___/___/___
Month Day Year

Applicant's Medicare Health Insurance Claim Number (HICN)
(exactly as shown on your Medicare card) | | | | | | | | | | | |

Plan Selection (check one)	Rate Structure (check one)
☐ Plan A/P020 ☐ Plan F/P025 ☐ High Deductible Plan F/P027 ☐ Plan G/P026 ☐ Plan N/P029	☐ Community Rating (10)
☐ Plan F/P025 With Innovative Discount Rider/B345	☐ Community Rating (20)

ⓕ

Payment Options: [☐ ABW (monthly) Type 1 ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] ⓖ

[Modal Premium Selected $ _____ Monthly Premium $ _____] ⓗ

Medicare Supplement Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.
PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge: YES NO

1. Are you covered under Medicare Part A? ☐ ☐
   If yes, what is your Part A effective date? ____/____/____ (Month / Day / Year)
   If no, what is your eligibility date? ____/____/____ (Month / Day / Year)
2. Are you covered under Medicare Part B? ☐ ☐
   If yes, what is your Part B effective date? ____/____/____ (Month / Day / Year)
   If no, what date do you plan to enroll? ____/____/____ (Month / Day / Year)
3. Did you turn age 65 in the last six months? ☐ ☐
   3a. Will you turn age 65 in the next six months? ☐ ☐
   3b. Did you enroll in Medicare Part B in the last six months? ☐ ☐
   If yes, what is your effective date? ____/____/____ (Month / Day / Year)

If you answered "YES" to any portion of question 3, you do not need to answer questions 8 – 24.

4. Are you covered for medical assistance through the state Medicaid program? ☐ ☐
   NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.
   If yes:
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ ☐
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ ☐

YES NO

5. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   Start Date ____/____/____ (Month / Day / Year) End Date ____/____/____ (Month / Day / Year)
   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ ☐
   If yes, please show requested date of termination/disenrollment ____/____/____ (Month / Day / Year)
   b. Was this your first time in this type of Medicare plan? ☐ ☐
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ ☐

YES NO

6. Do you have another Medicare Supplement policy in force? ☐ ☐
   a. If so, with what company and what plan do you have? _____
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ ☐
   If yes, enter requested date of termination/disenrollment ____/____/____ (Month / Day / Year)

	YES	NO
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)	☐	☐

a. If so, with what company and what kind of policy? _____

_____

b. What are your dates off coverage under the other policy? (If you are still covered under this plan, leave "END" blank) Start Date ____/____/____ (Month/Day/Year) End Date ____/____/____ (Month/Day/Year)

c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ ☐

If yes, please show requested date of termination/disenrollment. ____/____/____ (Month/Day/Year)

Under Open Enrollment, health questions 8 – 24 are not required to be answered.

8. Please provide your height _____(ft./in.) and weight _____(lbs.)

	YES	NO
9. Have you used tobacco products in the past 12 months?	☐	☐

Answer questions 10 and 11 only if you will be 68 years of age or younger on the effective date of the coverage for which you are applying. Otherwise, go to question 12.

	YES	NO
10. Do any of these apply to you:		
• Have end stage renal (kidney) disease	☐	☐
• Currently receiving dialysis	☐	☐
• Diagnosed with kidney disease that may require dialysis	☐	☐
• Diagnosed with or treated for internal cancer or melanoma within the past two years	☐	☐
• Admitted to the hospital as an inpatient within the past three months	☐	☐
• Have insulin dependent diabetes	☐	☐
• Use oxygen as a treatment for a diagnosed medical condition	☐	☐
11. Within the past two years, has a medical professional recommended or discussed as a treatment option, any of the following that has NOT been completed:		
• Hospital admittance as an inpatient	☐	☐
• Any surgery (including cataract surgery)	☐	☐
• Use of oxygen	☐	☐

Note: If you answered "YES" to any item in question 10 or 11, you will not qualify for coverage.

Answer questions 12 – 24 only if you will be over 68 years of age on the effective date of the coverage for which you are applying. Otherwise, skip questions 12 – 24.

	YES	NO
12. Have you been hospitalized or confined to a nursing home within the past 90 days, or have you been hospitalized two or more times in the past 12 months?	☐	☐
13. Do you require the use of a walker?	☐	☐
14. Are you bedridden, or do you require the use of a wheelchair?	☐	☐
15. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Dementia, or any other cognitive disorder?	☐	☐
16. Have you been diagnosed as having, or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)?	☐	☐
17. Are you taking prescription drugs for both diabetes and a heart condition (including high blood pressure)?	☐	☐
18. Are you taking anti-coagulant (blood thinner) drugs?	☐	☐

	YES	NO
19. Have you been advised by a medical professional that you may need surgery or a non-routine medical procedure within the next 12 months? (includes cataract surgery)	☐	☐
20. Within the past two years have you been diagnosed with, told by a medical professional that you have, or have you been treated for any of the following:		
• alcoholism; drug addiction (or drug abuse)	☐	☐
• internal cancer; leukemia; malignant melanoma;	☐	☐
• congestive heart failure; valvular heart disease; coronary artery disease; heart rhythm disorder, heart attack; heart surgery (includes bypass, balloon surgery, or placement of an arterial stent);	☐	☐
• insulin dependent diabetes;	☐	☐
• systemic lupus erythematosus (SLE);	☐	☐
• multiple sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease;	☐	☐
• fractures or amputation caused by disease; degenerative bone disease; severe arthritis involving major joints (hip, knee or shoulder) or the spine;	☐	☐
• liver disease; chronic kidney disorder; kidney failure; kidney dialysis;	☐	☐
• chronic obstructive pulmonary disease (COPD) or emphysema;	☐	☐
• an illness or condition for which you use oxygen;	☐	☐
• stroke; transient ischemic attack (TIA);	☐	☐
Note: If you answered "YES" to any of questions 12-20, you will not qualify for coverage.		
21. Do you have a Chronic Lung Disease, Chronic Bronchitis, or Breathing Disorder?	☐	☐
22. In the past 12 months have you received medical treatment in an assisted living facility?	☐	☐
If yes, please explain. _____		
_____		
23. Do you have a mental disease or disorder requiring medication (including depression)?	☐	☐

24. In the past 12 months, have you taken or been advised to take any prescription drugs, over the counter drugs, or medicines including narcotics, barbiturates or amphetamines? ☐ ☐

If "YES," indicate the specifics below:

Medication Name	Quantity Taken	Dosage	Prescribing Physician	Illness for Which Medication Prescribed	Date Last Prescribed

Important Statements to be Read by Medicare Supplement Applicant

(1) You do not need more than one Medicare Supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Optional Dental Plan Enrollment (Not required for issue of Medicare Supplement)

Dental Certificate C250 issued to the Delaware Group Insurance Trust

Plan Selection (check one) [☐ Applicant Only ☐ Applicant/Spouse] (l)

Spouse Information (only if Applicant/Spouse dental coverage is selected):

Spouse's Name _____ (m)
First Middle Initial Last

Date of Birth ____ / ____ / ____ Age _____ ☐ Male ☐ Female
Month Day Year

(k)

Choose your level of benefits: Schedule: [☐ A ☐ D ☐ E] (n)

Requested Effective Date ____ / ____ / ____
Month Day Year

Payment Options: [☐ ABW (monthly) ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] (o)

[Modal Premium Selected $ _____ Monthly Premium $ _____] (p)

Optional Life Insurance Application (Not required for issue of Medicare Supplement)

Life Policy [L728, Modified Whole Life Insurance] (r) Underwritten by Physicians Life Insurance Company

Face Amount:

[☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000 ☐ $9,000 ☐ $10,000] (s)

Optional Accidental Death Benefit (Rider LR-49):

☐ $5,000 ☐ $6,000 ☐ $7,000 ☐ $8,000 ☐ $9,000 ☐ $10,000 (t)

Beneficiary's Name _____ _____ _____ _____ (u)
First Middle Initial Last Relationship to Insured

Contingent Beneficiary's Name _____ _____ _____ _____ (q)
First Middle Initial Last Relationship to Insured

Do you have any existing life insurance or annuities? ☐ Yes ☐ No

[If yes, the Replacement of Life Insurance or Annuities form must be completed.] (v)

In the event of nonpayment of premiums, do you wish to use part of your cash value (if any) as a loan to pay the past due amount to keep your coverage in force? ☐ Yes ☐ No (w)

[Requested Effective Date ____/____/____] (x)
Month Day Year

Payment Options: [☐ ABW (monthly) ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual] (y)

[Modal Premium Selected $ _____ Monthly Premium $ _____] (z)

This statement applies only to the Medicare Supplement application: The Undersigned applicant and insurance producer certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the Medicare Supplement policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge.

This statement applies only to applicants enrolling for optional Dental Certificate C250: I am enrolling for Certificate C250 and the plan selected issued to the Delaware Group Insurance Trust. I understand no coverage is in force until the Company issues a certificate showing a Certificate Effective Date and the first full premium has been paid. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (aa)

This statement applies only to applicants for optional Life Insurance Policy L728: I understand that the Life Insurance coverage I am applying for will not be in force until my application has been received by Physicians Life Insurance Company and my first premium has been paid during my lifetime. I also understand that a reduced death benefit amount is payable during the first two years. This Product is being purchased separately from the Medicare Supplement product. Benefits are not inclusive to the Medicare Supplement product. This product may be purchased without purchasing the Medicare Supplement product. (bb)

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

X _____
Applicant's Signature

Date Application Completed ____/____/____ Dated at _____ _____
Month Day Year City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. I also certify that only Company approved sales material was used in connection with this sale [, and copies of all Life sales materials used were left with the applicant, if the existing Life policy is being replaced]. (dd)

This Medicare Supplement policy ☐ does replace ☐ does not replace any insurance presently in force.

[This Life Insurance policy (if applied for) ☐ does replace ☐ does not replace any insurance presently in force.] (cc)

X	X
Licensed Resident Insurance Producer's Signature	Licensed Resident Insurance Producer's Signature
Licensed Resident Insurance Producer's Printed Name	Licensed Resident Insurance Producer's Printed Name
Licensed Resident Insurance Producer's NPN	Licensed Resident Insurance Producer's NPN

To Be Filled Out By Insurance Producer

1. List any other health insurance policies you have sold the applicant which are still in force:

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force: